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In The Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

vs.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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12 pp

QUESTIONS PRESENTED FOR REVIEW

1. Where an insurance company fraudulently computes the premiums an employer must pay for employer-sponsored health care coverage, do the employer's state law claims for violation of common and statutory law "relate to" a benefit plan such that they are preempted by ERISA?

2. Are state insurance laws as applied to the claim of an employer against an insurance company arising out of the fraudulent computation of insurance premiums saved from preemption by ERISA's saving clause?

3. Where an employer purchases health insurance for its workers from an insurance company, the effect of which is to transfer risk from the employer to the insurance company, does the insurance create a "self-funded plan" such that the employer's claims against the insurance company cannot be saved from preemption?

4. Does ERISA or federal common law provide a remedy for an employer who has been defrauded in the purchase of health care insurance for its employees?

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OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS DELIVERED IN THIS CASE

The decision of the United States Court of Appeals for the Fourth Circuit is reported at 33 F.3d 309 (4th Cir. 1994). The decision of the United States District Court for the Northern District of West Virginia is not reported but can be found at 1993 WL 735796 (N.D. W. Va. July 2, 1993).

JURISDICTIONAL GROUNDS

The opinion and judgment of the United States Court of Appeals for the Fourth Circuit sought to be reviewed herein was entered on August 31, 1994. Jurisdiction to review that opinion and judgment by writ of certiorari is conferred on this Court by 28 U.S.C. § 1254 (1988). Petitioner did not seek a rehearing by the Fourth Circuit.

STATUTES INVOLVED IN THE CASE

Section 514 of ERISA reads, in pertinent part, as follows:

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b) **Construction and application.** (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

29 U.S.C. § 1144 (1988).

Section 502(a) of ERISA reads as follows:

(a) **Persons empowered to bring a civil action.** A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1).

29 U.S.C. § 1132(a).

Article 11 of Chapter 33 of the West Virginia Code (entitled "Unfair Trade Practices") states, in pertinent part, as follows:

§ 33-11-1. Declaration of purpose.

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty-five (Public Law fifteen, seventy-ninth Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. (1957, c. 97; 1974, c. 51.)

W. Va. Code § 33-11-1 (1974)

* * *

§ 33-11-3. Unfair methods of competition and unfair or deceptive acts or practices prohibited.

No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to section seven [§ 33-11-7] of this article to be, an

unfair method of competition or an unfair or deceptive act or practice in the business of insurance. (1957, c. 97; 1974, c. 51.)

W. Va. Code § 33-11-3 (1974)

§ 33-11-4. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

* * *

(5) False statements and entries. —(a) No person shall knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) No person shall knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly omit to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

* * *

W. Va. Code § 33-11-4 (1974)

STATEMENT OF THE CASE

Background Facts

Tri-State Machine, Inc. ("Tri-State")[1] contracted with Nationwide Life Insurance Company ("Nationwide") to have Nationwide provide insurance for Tri-State's employees. Tri-State purchased a combination of health, life, prescription drug, dental and total disability insurance (the "Policy") which was used to fund the employee benefit plan sponsored by Tri-State (the "Tri-State benefit plan"). Tri-State's premium payments were to be calculated according to a Cash Priority Plan Funding Agreement (the "Funding Agreement").

Nationwide and its agents administered the Tri-State benefit plan and paid claims submitted by Tri-State's employees as contractually bound to do under the Policy. The Policy required Nationwide to provide insurance to each of Tri-State's employees and their families, and to administer the claims. For example, Nationwide and its agents would determine whether an employee's medical claim was covered and, if so, the claim was paid by Nationwide. Tri-State did not pay claims or have any role in the claims adjudication process. Tri-State had no role in the administration of the Tri-State benefit plan. In short, Tri-State had no discretion relative to the plan and, as such, was not a plan fiduciary within the meaning of ERISA.

Like any employer that purchases insurance for its employees, Tri-State's insurance premiums were based upon a number of factors: volume of claims, nature of claims, volume of life insurance, number of lives insured and, of course, the amount of those claims. Under the Funding Agreement, Nationwide reported claims information to Tri-State and collected premiums

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[1]Tri-State has no parent or subsidiary corporations.

based on that information. The premiums were the sum of various factors: an amount to cover Nationwide's cost of administering the plan; another amount equal to the aggregate of all claims under $25,000 per year/per employee; plus an additional amount to cover the risk assumed by Nationwide to absorb any claims per individual that exceeded $25,000 in any given policy year and the risk assumed by Nationwide of paying any and all claims that exceeded the annual cap.[2] Thus, Nationwide's exposure depended upon the amount and timing of the payment of claims to Tri-State's employees.

As far as Tri-State could determine, Nationwide properly determined coverage issues over the course of the years that the insurance was in place. Likewise, where Nationwide determined that the Policy provided coverage, it timely paid claims on behalf of Tri-State's employees to their health care providers.

However, when it came time for Nationwide to report claims information to Tri-State and to calculate Tri-State's insurance premium, Nationwide acted dishonestly in an attempt, successful to date, to save itself money. For purposes of calculating Tri-State's obligation to pay premiums, Nationwide manipulated the posting of dates on which Nationwide paid claims so as to increase Tri-State's insurance premium. Nationwide fraudulently reported to Tri-State that claims were paid later than when actually paid, so as to "spread out" the claims of employees. Spreading out the time periods in which claims were paid by Nationwide created the appearance, falsely, that certain Tri-State employees had claims less than or equal to $25,000 per year, when in fact their claims exceeded $25,000. In addition, in direct violation of the terms of the Funding Agreement, Nationwide

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[2]The Funding Agreement contained a cap on the premiums that Tri-State was required pay in any given year. For example, the maximum amount payable during the first year of the Funding Agreement was approximately $130,000.

grouped medical, dental, prescription and major medical claims into one monthly amount which was applied towards the "monthly policyholder liability limit amount," so as to increase Tri-State's insurance premium.

Nationwide also reported claims as having been paid in the year subsequent to when actually paid to avoid the annual cap on Tri-State's maximum premium liability. In other words, Nationwide ceased posting claims to Tri-State's account before the end of any given plan year. When a new year began under the Funding Agreement, wherein Tri-State would be fully responsible for the maximum premium liability, Nationwide resumed posting claims to Tri-State's account. Claims which had been paid months before were suddenly posted to Tri-State's account and were applied against Tri-State's new premium limit. This purposeful manipulation of information caused Tri-State's premiums to be much higher than they otherwise would have been. The manipulation of data fraudulently allowed Nationwide to recoup, on a dollar-for-dollar basis, more than it was entitled to under the terms of the Funding Agreement.

Proceedings Below

After discovering Nationwide's fraud, Tri-State sued Nationwide in West Virginia state court. The complaint alleged various theories of recovery such as breach of contract, breach of implied covenant of good faith and fair dealing, statutory "bad faith," and violation of West Virginia insurance laws. Nationwide removed the case to the United States District Court for the Northern District of West Virginia alleging that Tri-State's claims were governed and preempted by ERISA. The District Court ruled that diversity jurisdiction existed pursuant to 28 U.S.C. § 1332(a) (1988).

Initially, Tri-State moved for partial summary judgment seeking a determination from the District Court that ERISA did

not preempt Tri-State's state law causes of action because the fraudulent conduct involved the sale of insurance and did not "relate to" the administration of an ERISA plan. Although it did not formally dismiss Tri-State, the District Court denied the motion, ruling that all of Tri-State's claims based on West Virginia law were preempted by ERISA.[3] The District Court certified the preemption issue to the Fourth Circuit; however, the appellate court declined to hear the issue at that time.[4]

Tri-State later sought entry of a final order under Rule 54(b) in an attempt to have the District Court acknowledge that it had effectively dismissed Tri-State's state law claims from the case. The entry of a final judgment under Rule 54(b) would have allowed Tri-State to appeal the ERISA preemption issue.

On July 2, 1993, the District Court issued an order in which it refused Tri-State's request for a Rule 54(b) final judgment and refused to alter its finding that Tri-State's state law causes of action were preempted by ERISA.[5] The District Court further refused to find that the facts, as alleged, formed the basis for federal common law or ERISA claims and, instead, issued summary judgment *sua sponte* for Nationwide. This final order was appealed to and heard by the Fourth Circuit pursuant to 28 U.S.C. § 1291 (1982).

The Fourth Circuit affirmed by a 2-1 majority.[6] The Fourth Circuit's analysis was similar to that of the District Court: Tri-State's claims "related to" an ERISA plan; the insurance

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[3]The District Court's opinion and order denying Tri-State's motion for summary judgment is found at pages 1a - 4a of the appendix to the petition.

[4]The Fourth Circuit's order denying permission to appeal is found at page 7a of the appendix.

[5]The District Court's opinion and order granting summary judgment against Tri-State is found at pages 8a - 14a of the appendix.

[6]The Fourth Circuit's opinion and order is found at pages 15a - 34a of the appendix.

laws asserted to be applicable were not "saved" from preemption; therefore, all of Tri-State's claims arising under West Virginia common or statutory law were preempted. As to Tri-State's argument that claims arising under West Virginia's Insurance Code were "saved" from preemption by ERISA's saving clause, both courts rotely cited precedent standing for the proposition that self-funded plans are exempt from state insurance laws by virtue of the "deemer" clause. ERISA Section 514(b)(2)(B).

These analyses failed to recognize that Nationwide is not an employee benefit plan but, rather, an insurance company. The lower courts mistakenly reasoned that since the Policy had some stop-loss insurance features, the Policy was actually a self-funded plan which could not be deemed to be an insurance company or an insurer. The Fourth Circuit additionally held that the insurance provision of the West Virginia Code which Tri-State sued under was not a "law regulating insurance" within the meaning of ERISA's saving clause.

Tri-State was defrauded in the purchase of insurance for its employee benefit plan. Various state law causes of action were brought against Nationwide to remedy the wrong, but each cause of action was held to be preempted, even though the face of the Policy clearly states "SUBJECT TO THE LAWS OF THE STATE IN WHICH IT IS DELIVERED." Thus far Tri-State has been left without either state or federal remedies against Nationwide to redress an obvious insurance fraud.

ARGUMENT

I. IMPORTANCE OF DECISION

A. Importance of Encouraging the Development and Continuation of Employer-Sponsored Benefit Plans and Preventing Insurance Company Fraud.

It is very important for the Court to hear this appeal because the matters at issue affect the societal and legislatively-expressed interest in encouraging employers to sponsor health care benefits for their employees.

This case is also immensely important because it affects the enforceability of every state's Unfair Trade Practices Act against insurance companies in the sale of insurance products. Over 27 states have enacted an unfair trade practices act based on the model act proposed by the National Association of Insurance Commissioners.[7] If this case is not heard, Nationwide and other insurers can be expected to continue to engage in their fraudulent business practices under the protection of the ERISA preemption shield.

There is every reason to believe that the manipulation of claims to generate increased premiums is a widespread practice within the multi-billion dollar business[8] of providing insurance products to fund ERISA welfare benefit plans (*i.e.*, employer-sponsored health care). Yet, to date, this Court has not had occasion to address the effect of ERISA on regulating the sale of insurance products by insurance companies to employers within the context of employer-sponsored benefit plans.

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[7]Douglas G. Houser, *Unfair Claims Settlement Practices Act - How the Courts Have Interpreted the Act,* 15 The Forum 336 (1979).

[8]According to the Statistical Abstract of the United States 1994, Table No. 155, businesses paid $152.7 billion in private health insurance premiums in 1991.

The end result of decisions like the one being appealed from - decisions which broadly interpret the scope of ERISA preemption, yet narrowly construe the saving clause - is the opposite of what Congress intended.

If an individual or a corporation bought insurance in West Virginia and was victimized by the type of fraud Tri-State alleges against Nationwide, those persons would have claims under West Virginia's Unfair Trade Practices Act for compensatory and punitive damages. However, under the decisions issued by the District Court and the Fourth Circuit in this case, an employer who funds a benefit plan by purchasing an insurance package from an insurance company is deprived of remedies against an insurance company - remedies that any other purchaser of insurance would possess. That result is wrong and will have strong negative repercussions throughout the United States because it allows insurance companies to raise the shield of ERISA preemption and protect themselves not only against the employee beneficiaries of a welfare plan, but against employers who sponsor plans. Tri-State's counterparts within the small business community will surely be apprised of Tri-State's inability to obtain redress against Nationwide's fraud and will be unquestionably opposed to running the same risk.

The model unfair practices act is designed to force insurance companies to conform to certain standards of conduct. Likewise, states throughout the nation have developed other statutory and common law remedies which vigorously protect purchasers of insurance against insurance fraud. Under the rationale of cases extending ERISA preemption to insurance fraud, these state law protections are nonexistent whenever an insurance product is purchased to fund an employee benefit plan. Yet, the sale of and payment for insurance is surely not an area Congress sought to preempt when ERISA was enacted. Indeed, Congress

specifically carved out of preemption, through the saving clause, laws regulating the business of insurance.

Employers should be given every benefit and should be extended the protection of state insurance laws where they purchase insurance related to an ERISA employee benefit plan. The purposes of ERISA are furthered if ERISA is interpreted to limit the remedies of a participant against his employer, thereby creating an incentive for the employer to provide health benefits to its employees. However, if state-provided remedies are stripped from an employer purchasing insurance for a plan, then the Court has placed a serious burden on an employer providing health benefits for its employees.

It is Tri-State's contention that Congress intended to restrict the displacement of state law to those areas with which ERISA is directly concerned—*i.e.*, primarily the operation and administration of plans, and to leave state law in place to the extent it does not affect those core concerns.

The effect of the lower courts' decisions in this case is that insurance companies have no strong disincentive to manipulate premium calculations to defraud employers in connection with employer-sponsored health care. Nationwide and other companies in the insurance business are currently enjoying this windfall and, as such, have no incentive to ferret out and alter the fraudulent practices of their employees. This is especially significant when one considers that insurance companies process billions of dollars of claims per month from which employer-sponsored health care premiums are calculated.

B. Strong Concerns of Federalism are at Stake.

The effect of the Fourth Circuit's decision and other decisions like it is to take power from the States and give it to the federal government.

It is well established that Congress can supplant state statutes and common law with federal law, especially where an issue of such importance as employee benefits is at stake. ERISA's preemption provisions are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987).

However, it is equally clear that with the passage of ERISA, Congress intended to retain in the States the ability to regulate insurance companies and insurance practices. "We also must presume that Congress did not intend to pre-empt areas of traditional regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985).

States have a keen interest in controlling and policing the actions of insurance companies, and each state goes about it differently. States like West Virginia have established an Insurance Commission and have enacted detailed laws and regulations regarding all aspects of insurance. West Virginia and other states also devote substantial time, money and effort to protect their citizens in their dealings with insurance companies. Indeed, in virtually every state, employers comprise a huge segment of those purchasing insurance.[9]

For courts such as the Fourth Circuit to interpret ERISA so as to displace the bulk of state insurance laws as they might be invoked by sponsors of employee benefit plans, is to rob the

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[9]Employers in West Virginia, for example, pay over $20 million per year in accident and health insurance premiums. *1992 Annual Report of the West Virginia Insurance Commissioner.* Insurance companies pay an insurance premium tax to the State of West Virginia when insurance is purchased by West Virginia resident companies. The purpose of the premium tax is to help defray the cost of the insurance commissioner, staff and regulating agencies to "regulate insurance."

States of a very large and important area of traditional state concern. Such a broad reading of ERISA also unnecessarily and improperly empowers insurance companies.

This case is not about paying claims to any care provider; nor is this case about providing benefits to or for any participant or beneficiary. This case is about one company (Nationwide) breaching its contract with another company (Tri-State). It is about the lower courts ignoring a contract which, as presented and sold, clearly stated "Subject to the Laws of the State in Which it is Delivered." By stripping state law remedies from an insurance purchaser, the lower courts have also taken from the States their rights to protect employers or other purchasers of insurance. This case is merely a billing dispute over the billing procedures of one company to another company.

Insurance companies are not placed under an extra burden by being required to comply with state laws relating to the sale of insurance products for employee benefit plans. To the contrary, if the same type of policies as in question here are sold outside the arena of employee benefits, insurance companies must comply with state law (like West Virginia's Unfair Trade Practices Act). Similarly, insurance companies are required to comply with the same state insurance laws in the sale of every other type of insurance product. There is no good reason for relieving insurance companies of such burden for the sale of employee benefit plan policies.

Because federal courts throughout the country are tending to expansively construe the scope of ERISA preemption and narrowly construe the saving clause, the balance of power between the States and the federal government is at stake. This is a concern that has a very real effect on all States, and on all employers and employees who choose to do business in any particular state. It is an issue that strikes at the core of our federalism. As such, this case presents questions of important public concern.

II. THE CIRCUITS ARE SPLIT AS TO THE TEST TO BE USED IN DETERMINING THE SCOPE OF THE "RELATE TO" CLAUSE, THE "SAVING CLAUSE" AND THE "DEEMER CLAUSE" OF SECTION 514 OF ERISA

One of the primary goals of Congress in enacting ERISA was to encourage the creation and continuation of employer-sponsored employee benefit plans by defining, yet limiting, the universe of claims and remedies that may be sought by plan beneficiaries. Section 514 of ERISA, 29 U.S.C. § 1144, the broad preemption provision, minimizes the burden upon plans and their sponsors of complying with complex and conflicting state regulations. State laws that "relate to any employee benefit plan" are preempted. 29 U.S.C. § 1144(a).

At the same time Congress sought to preempt this area of federal concern, Congress also expressly permitted the States to continue to regulate insurance companies via Section 514(b)(2)(A) of ERISA (the "saving clause"), 29 U.S.C. § 1144(b)(2)(A) (" . . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . "). The "deemer clause" of ERISA then states that no employee benefit plan "shall be deemed to be an insurance company or other insurer." 29 U.S.C. § 1144(b)(2)(B) (1988). Congress feared that if this provision were not added, an employee benefit plan might, itself, be forced to follow a variety of burdensome state insurance laws and regulations.

The foregoing three clauses in Section 514 of ERISA affect the scope of ERISA preemption. A separate test has been developed for each clause, and the circuits are split in how they apply the tests for each clause.

A. Judicial Construction of the "Relate To" Clause.

The circuits are split as to the proper construction of the "relate to" clause. The central question giving rise to the split is

whether ERISA preempts claims that relate in some manner to ERISA plans, but for which ERISA provides no express remedy.

Some circuits have held that the "relate to" clause of ERISA Section 514(a) is to be given a broad construction and, consequently, that courts must create federal common law rights and remedies to deal with such preempted claims. Other circuits have come to a contrary conclusion, reasoning that although ERISA broadly preempts all areas with which it is concerned, the "relate to" clause should be narrowly construed when areas of traditional state concern are at stake for which ERISA provides no remedies.

In the case in question, the Fourth Circuit held Tri-State's state law claims to be preempted, even though ERISA provides no remedy for the claims alleged, and even though Tri-State, as a non-fiduciary plan sponsor, apparently is not authorized to sue under ERISA's civil enforcement provisions.

In addition to the Fourth Circuit's decision below, a case decided by the Eleventh Circuit provides a good example of the view that ERISA preempts all claims, even those not implicating the rights of plan participants and beneficiaries. In *First Nat'l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc.*, 960 F.2d 1546 (11th Cir. 1992), *cert. denied*, ___U.S. ___, 113 S.Ct. 1045 (1993), an insurance company brought claims against an employer for the employer's failure to adhere to certain conditions under which a group insurance policy was issued, such as an alleged failure to maintain 75% employee participation in the plan. The insurance served as an employer-sponsored benefit plan. Although ERISA obviously has no express provisions or remedies addressing such a dispute, the Eleventh Circuit found that, because the claims "related to" a plan, all state laws concerning such a dispute were preempted. Consequently, any remedy must be under ERISA or federal common law to fill the "gaps" of ERISA.

The Fourth and Eleventh Circuits are not alone in being unable to risk the temptation of expanding the scope of federal law to areas of traditional state law concern. *See, e.g., Consolidated Beef Indus. v. New York Life Ins. Co.*, 949 F.2d 960, 964 (8th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S.Ct. 1670 (1992) (employer has no remedy because its claim of misrepresentation in the sale of an insurance program related to the plan and was, therefore, preempted); *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 794 (11th Cir. 1989), (claims arising out of misconduct in the sale of a plan are preempted, since "a state law claim relates to a plan for preemption purposes as long as it is not 'wholly remote in content' "); *Washington Nat'l Ins. Co. v. Hendricks*, 855 F. Supp. 1542 (W.D. Wis. 1994) (where an insurer sued an employer for unpaid premiums and the employer counterclaimed for what it alleged to be the improper termination of an insurance policy, held that these actions related to an ERISA plan and that courts were empowered to create causes of action for breach of contract and similar state law theories under ERISA).

Other circuits, in contradiction to the Fourth, Eighth and Eleventh Circuits, have limited the preemptive effect of the "relate to" provision to benefits administration and processing issues. These courts hold that ERISA concerns itself only with the rights of fiduciaries and beneficiaries in the administration of a plan, recognizing that Congress did not intend to preempt the application of state laws to what are essentially commercial disputes.

For example, in *Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994), an employer who sponsored a plan brought claims of negligence and common law fraud against a consultant to the employee benefit plan administrators. The employer alleged that the consultant failed to

diversity of citizenship and federal question, arguing that Tri-State's complaint is completely preempted by 29 U.S.C. § 1001 et seq., the Employee Retirement Income Security Act of 1974 ("ERISA"). The Court subsequently denied Tri-State's motion for remand finding that diversity jurisdiction existed, but declined to rule on the ERISA preemption issue.

Tri-State now moves for partial summary judgment on the ERISA preemption issue. Nationwide claims that the preemption issue cannot be determined by summary judgment, and moves to have the motion stricken. In its answer, Nationwide asserts as its first affirmative defense that Tri-State's complaint is preempted by ERISA. Tri-State now seeks a ruling by the Court that, as a matter of law, its claims are not preempted by ERISA. Summary judgment is an appropriate vehicle for such a ruling. Therefore, Nationwide's motion to strike is DENIED.

Proceeding to the merits of Tri-State's motion, the complaint clearly relates to an employee welfare benefit plan as defined in ERISA § 1002(1)(A). Tri-State argues that Nationwide lacks standing to assert its preemption defense. Said argument is without merit. There is no requirement that a defendant have standing to be sued.

Apparently, Tri-State seeks to circumvent preemption by arguing that ERISA is designed to protect employees and beneficiaries; that it is not applicable to contracts between employers and insurance companies. However, ERISA provides broad coverage, including actions such as the one before the Court. Both parties are definitely plan fiduciaries. As such, § 1132(a)(2) permits Tri-State to maintain a § 1109 action against Nationwide.[1]

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[1]Even if Tri-State was not a fiduciary, it would probably be able to maintain a suit against Nationwide under ERISA federal common law. *See Plumbers & Steamfitters Local Union No. 152 etc. v. Bland*, 745 F. Supp. 1172 (N.D.W.Va. 1990).

Therefore, under § 1144(a), ERISA preempts all of Tri-State's claims based upon West Virginia laws relating to the health insurance plan upon which its complaint is based. *See FMC Corp. v. Holliday,* 111 S. Ct. 403 (1990); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985); *Thompson v. Talquin Bldg. Products Co.,* 928 F.2d 649 (4th Cir. 1991); *Powell v. Chesapeake & Potomac Tel. Co.,* 780 F.2d 419 (4th Cir. 1985).

Having so found general preemption, Tri-State argues that its claims based upon the West Virginia Trade Practices act are saved from preemption under § 1144(b)(2). This savings clause, however, is limited by § 1144(b)(2)(B), also known as the "deemer" clause. The deemer clause excludes self-funded benefit plans from the savings clause. *FMC Corp. v. Holliday, supra.*

The plan involved herein is a self-funded plan. Therefore, under the deemer clause, the plan cannot be regulated by the West Virginia Trade Practices Act. The fact that Nationwide provides stop-loss coverage does not change this outcome. *Thompson v. Talquin Bldg. Products Co., supra.* Also, the outcome is not changed by the fact that Nationwide provides administrative claims processing functions for Tri-State. *Powell v. Chesapeake & Potomac Tel. Co., supra.*

Accordingly, the Court is of the opinion that plaintiff's motion for partial summary judgment should be DENIED.

It is so ORDERED.

The Clerk is directed to transmit certified copies of this Memorandum Opinion and Order to counsel of record herein.

ENTER:

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

Filed September 23, 1991

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
February 27, 1992

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO. 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

ORDER

Currently pending is the plaintiff's motion for reconsideration or, in the alternative, for certification to the Fourth Circuit Court of Appeals, pursuant to 28 U.S.C. § 1292(b). Defendant has filed its opposition to both motions.

In regard to the plaintiff's motion for reconsideration of the Court's Memorandum Opinion and Order, entered September 23, 1991, the Court finds that the plaintiff has cited no grounds warranting reconsideration. The plaintiff's action is completely preempted by 29 U.S.C. § 1001 et seq., the Employee Retirement Income Security Act of 1974 ("ERISA"). Therefore, plaintiff's motion for reconsideration is DENIED.

In regard to plaintiff's motion for the Court to certify an appeal of its Memorandum Opinion and Order to the Fourth Circuit pursuant to 28 U.S.C. § 1292(b), the Court is of the opinion that its ruling does involve a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal may materially advance the ultimate termination of this action. The Court agrees with the defendant that certifications are the exception, not the rule. However, there

is no doubt that the Court's ruling on the question of law, in effect, eliminates the plaintiff's case. Furthermore, as aptly cited by the plaintiff, the ERISA preemption question "was caught up in the 'ERISA quicksand.' " The Court believes that the law is not as clear as the defendant asserts and that there is substantial ground for difference of opinion.

Accordingly, the Court is of the opinion that the plaintiff's motion to certify an appeal of the Court's Memorandum Opinion and Order to the Fourth Circuit is hereby GRANTED. This finding is made pursuant to 28 U.S.C. § 1292(b) which grants appellate jurisdiction upon the Fourth Circuit Court of Appeals which may, in its discretion, permit an immediate appeal to be taken if, within ten (10) days of entry of this Order, an application is made. Furthermore, the Court hereby STAYS all further proceedings before the Court.

It is so ORDERED.

The Clerk is directed to transmit certified copies of this Order to counsel of record herein.

ENTER:

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
March 26, 1992

TRI-STATE MACHINE, INCORPORATED,
Petitioner

v. No. 92-8022

NATIONWIDE LIFE INSURANCE COMPANY, an Ohio Corporation CA-90-00-27-W(K)

Respondent

ORDER

Petitioner has filed a petition for permission to appeal an interlocutory order pursuant to 28 U.S.C. 1292(b).

The Court denies the petition for permission to appeal.

Entered at the direction of Judge Niemeyer, with the concurrence of Judge Hall and Judge Phillips.

For the Court,

/s/ JOHN M. GREACEN

Clerk

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
JULY 2, 1993

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO. 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

MEMORANDUM OPINION AND ORDER

Once again, the plaintiff Tri-State Machine, Inc. ("Tri-State") petitions the Court to reverse itself and provide a favorable ruling that Tri-State's complaint, which asserts only state causes of actions against defendant Nationwide Life Insurance Company ("Nationwide"), is not preempted by § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA") as set forth at 29 U.S.C. § 1144. In pursuit of its goal, Tri-State has filed a "Conditional Motion for Entry of Final Judgment under Rule 54(b) or, Alternatively, Motion for Summary Judgment and Request for Entry of Final Judgment."[1] Nationwide filed its opposition motion to which Tri-State replied. In addition, Nationwide filed a motion for Rule 11 sanctions which is opposed by Tri-State.

To put this matter in perspective, a brief review of the procedural history is in order. This action was originally filed in the Circuit Court of Ohio County, West Virginia, on February 28,

[1]On the same date, Tri-State also filed a motion for leave to file an amended complaint, a motion to compel, and a motion for oral argument. Said motions have also been fully briefed.

1990. On March 29, 1990, Nationwide removed it, basing jurisdiction on ERISA preemption as well as diversity of citizenship. On April 24, 1990, Tri-State filed its motion for remand, which included a twenty page brief arguing that there was no ERISA preemption, and that diversity was lacking due to the direct action exception found at 28 U.S.C. § 1332(C)(1). Finding the direct action exception inapplicable and that diversity jurisdiction existed, the Court denied the remand motion. The Court did not rule on the preemption issue.

On April 24, 1991, Tri-State filed its motion for partial summary judgment, with attached memorandum, seeking a ruling that its complaint is not preempted by ERISA. On May 17, 1991, Nationwide filed its opposition brief, asserting that Tri-State's entire complaint is preempted by ERISA. Tri-State filed no reply brief.[2] By Memorandum Opinion and Order entered on September 23, 1991, the Court denied Tri-State's motion, holding that all of its state law claims were preempted by ERISA.[3]

On November 29, 1991, Tri-State filed its motion for reconsideration of the Court's denial of its partial summary judgment motion. Alternatively, Tri-State moved for certification pursuant to 28 U.S.C. § 1292(b), should the Court not reconsider its prior ruling. On December 16, 1991, Nationwide filed its opposition to both motions. Again, Tri-State filed no reply brief. By Order entered February 21, 1992, the Court denied Tri-State's motion for reconsideration, but granted its motion for certification. On

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[2]Tri-State complains about Nationwide's alleged misrepresentations of facts and misleading of the Court in its opposition brief regarding the funding of the insurance policy. If this in fact was the case, a reply brief was the proper means to bring it to the Court's attentions.

[3]Tri-State takes issue with the Court's ruling in regard to the "savings" clause and "deemer" clause, found at 29 U.S.C. § 1144(b)(2), claiming that "neither Plaintiff nor Defendant briefed that issue." In its motion for partial summary judgment, Tri-State specifically alleged as its second ground that "29 U.S.C. § 1144(b)(2) exempts the plaintiff's claim from ERISA."

March 26, 1992, the Fourth Circuit Court of Appeals denied Tri-State's petition for permission to appeal.

On April 7, 1992, Tri-State filed its motion to vacate and reenter order of certification, asserting that the Fourth Circuit denied the petition because it was not timely filed. On April 23, 1992, Nationwide filed its opposition brief. Tri-State's reply brief was filed on May 7, 1992. By Order entered June 16, 1992, the Court denied Tri-State's motion, finding that the Fourth Circuit's denial was most likely upon the merits since untimeliness could easily have been remedied if the Fourth Circuit had so desired. The Court also ordered Tri-State to indicate whether it intended to pursue an ERISA claim. By notice filed July 9, 1992, Tri-State informed the Court that it intended to pursue this action under ERISA. However, to date, there has been no effort by Tri-State to amend its complaint to state a cause of action under ERISA.

Instead, Tri-State has filed the motion currently before the Court, as well as a motion for leave to amend two paragraphs of its complaint, with the specific design to avoid ERISA preemption and proceed on the state law claims asserted in its complaint.[4] Specifically, Tri-State asserts that the Court erred by finding the "deemer" clause[5] applicable and that Tri-State was a fiduciary under ERISA. However, neither of these contentions is material to a finding of complete preemption under ERISA.

The Rule 54(b) motion merits little discussion. The Court has not dismissed any claims asserted by Tri-State. The Court

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[4]Specifically, Tri-State seeks to amend its complaint to allege that the group insurance policy was not self-funded, in furtherance of its attempt to avoid preemption. Tri-State makes no effort to also add an ERISA claim to its complaint.

[5]The "deemer" clause is found at § 406(b)(2)(B) [sic] of ERISA, 29 U.S.C. § 1144(b)(2)(B). The "savings" clause is found at § 406(b)(2)(A) [sic] of ERISA, 29 U.S.C. § 1144(b)(2)(A).

denied Tri-State's partial summary judgment motion. Therefore, there is nothing to enter partial judgment upon. The proper mechanism for review of this decision was certification, which the Fourth Circuit denied. Accordingly, Tri-State's Rule 54(b) motion is DENIED.

Preemption under ERISA is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 407 (1990). If the state cause of action "relates to" an employee welfare benefit plan, it is preempted. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478 (1990). Tri-State concedes: "It is clear that the employee benefit plan sponsored by Plaintiff is an 'employee welfare benefit plan' for purposes of ERISA." Furthermore, as stated in its memorandum of law in support of motion to remand, filed on April 24, 1990, Tri-State characterized its complaint as follows:

> . . . Specifically, it is alleged that defendant breached its duties to administer the benefits program and failed to determine what claims should be paid or what claims should not be paid. It is alleged that defendant failed to timely process claims with the intent of imposing liability on plaintiff under the stop-loss provisions of the plan, and that defendant deliberately mismanaged the contract. It is alleged that defendant breached its fiduciary duty to plaintiff and that defendant breached the implied covenants of good faith and fair dealing. It is also alleged that defendant misrepresented pertinent facts of the insurance policy and committed the common law and statutory offense of "insurance bad faith." Further, it is alleged that defendant's actions violated the applicable law of the State of West Virginia, including the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices.
>
> . . . .

> However, it is plaintiff's contention that its claim is based entirely and solely upon state law and does not invoke ERISA original jurisdiction.

More than three years later, Tri-State's position has not changed. In its reply brief, filed on May 20, 1993, Tri-State states: "In our case, Plaintiff, as an insurance purchaser, is seeking damages for fraudulent conduct under an insurance contract." It is inconceivable to the Court how Tri-State can continue to argue that its complaint for improper plan administration does not relate to the employee welfare benefit plan alleged to have been improperly administered by Nationwide. *See Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 288 (2nd Cir. 1992) ("The fraud alleged 'relates to' an ERISA-regulated employee benefit plan because it concerns the conduct of a fiduciary and third parties in relation to the plan."); *Consolidated Beef Industries, Inc. v. New York Life Ins. Co.*, 949 F.2d 960, 963 (8th Cir. 1991) ("Given ERISA's broad pre-emption provision, state law claims for improper plan administration are pre-empted."); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1897) [sic] ("However, if a state law claim arises out of the administration of benefits under a plan, the claim is preempted").

The fact that Tri-State claims that it is not a fiduciary is immaterial to preemption. Although the Court has no doubt that Tri-State is a fiduciary, and has so found, if it were not, it would still be able to pursue a federal common law ERISA remedy under *Provident Life & Acci. Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990). *See Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund*, 794 F.2d 221 (6th Cir. 1986). Accordingly, as a matter of law, the Court holds that all of the claims asserted in Tri-State's complaint relate to the employees welfare benefit plan.

Tri-State's final argument is that the "deemer" clause is inapplicable and that the "savings" clause would not exempt its

claims from ERISA preemption. Even if the Court were to reverse its finding that Tri-State was self-funding, and hold that the "deemer" clause was inapplicable, all of Tri-State's claims would still be preempted. The "savings" clause only applies to state laws that "regulate insurance." Whether a state law regulates insurance is a question of federal law. Federal courts have consistently held that "bad faith" claims as well as "deceptive and unfair trade practices" claims, whether based upon statute or common law, are not laws that regulate insurance.

In order for a state law to regulate insurance it must have the effect of "spreading and underwriting of a policyholders' [sic] risk." *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (1985). The state laws asserted by Tri-State against Nationwide do not do so. The state laws asserted do not regulate the type of insurance contract which could be issued, nor mandate any benefits which must be included in the insurance contract. Simply put, the state laws do not regulate insurance within the meaning of the "savings" clause. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Stuart Circle Hospital Corp. v. Aetna Health Management*, ___ F.2d ___ (4th Cir. June 2, 1993); *Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991). Accordingly, the "savings" clause is inapplicable.

Therefore, it is still the opinion of the Court that § 406 [sic] of ERISA, 29 U.S.C. § 1144(a), preempts all of Tri-State's claims asserted in its complaint. In that this issue has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the Court hereby GRANTS

summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.[6] *See Pension Ben. Guaranty Corporation v. Mize Co.*, 987 F.2d 1059, 1061 (4th Cir. 1993); *Portsmouth Square, Inc. v. Shareholders Protective Committee*, 770 F.2d 866, 869 (9th Cir. 1985) ("For example, *sua sponte* summary judgment is appropriate where one party moves for summary judgment and, after hearing, it appears from all the evidence presented that there is no genuine issue of material fact and the *non-moving* party is entitled to judgment as a matter of law."). In light of the Court's ruling herein, all remaining motions are DENIED.

It is so ORDERED.

Judgment shall be entered accordingly, and this action shall be dismissed and removed from the docket of the Court.

The Clerk is directed to transmit certified copies of this Memorandum Opinion and Order to counsel of record herein.

ENTER: July 2, 1993

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

[6]In essence, by granting summary judgment against Tri-State, the Court has made possible the appeal Tri-State sought in its Rule 54(b) motion.

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

Tri-State Machine, Incorporated,
Plaintiff-Appellant,

v. No. 93-1971

Nationwide Life Insurance Company,
Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of West Virginia, at Elkins.
William M. Kidd, Senior District Judge.
(CA-90-27-W-K)

Argued: March 9, 1994

Decided: August 31, 1994

Before NIEMEYER and LUTTIG, Circuit Judges,
and PHILLIPS, Senior Circuit Judge.

Affirmed by published opinion. Judge Niemeyer wrote the opinion, in which Senior Judge Phillips joined. Judge Luttig wrote a separate dissenting opinion.

COUNSEL

ARGUED: David B. Fawcett, III, BUCHANAN INGERSOLL PROFESSIONAL CORPORATION, Pittsburgh, Pennsylvania, for Appellant. Gregory Darwin Port, CHORPENNING, GOOD & MANCUSO CO., L.P.A., Columbus, Ohio, for Appellee. **ON BRIEF:** James W. Forsyth, BUCHANAN INGERSOLL PROFESSIONAL CORPORATION, Pittsburgh, Pennsylvania; Ray A. Byrd, SCHRADER, RECHT, BYRD, BYRUM & COMPANION, Wheeling, West Virginia, for Appellant. Philip F. Brown, CHORPENNING, GOOD & MANCUSO CO., L.P.A., Columbus, Ohio, for Appellee.

give timely advice, improperly calculated pension benefits, proposed and drafted a useless plan amendment, and deliberately concealed the cost of the amendment and its eventual uselessness. The Tenth Circuit recognized that claims obviously having some relationship to an ERISA plan did not "relate to an ERISA plan" within the meaning of ERISA's preemption provision:

> [It] is clear that the state law claims here do not relate to an ERISA plan. The state laws involved do not regulate the type of benefits or terms of the plan; they do not create reporting, disclosure, funding, or vesting requirements for the plan; they do not affect the calculation of benefits; and they are not common law rules designed to rectify faulty plan administration. (Citation omitted.) Similarly, plaintiffs are not employees resorting to state law to avail themselves of an alternative cause of action to collect benefits . . .

Id. at 1065.

Other circuits addressing the scope of the "relate to" clause align themselves with the Tenth Circuit in *Airparts*. *See, e.g., Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (ERISA did not preempt an employee's claim against insurance agents for fraudulently misrepresenting a plan's coverage); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989) (misrepresentation of the terms of a plan to induce participation was not preempted when Congress has not provided a remedy for the wrong and the employees' claims do not relate to any plan benefit), *cert. denied*, 493 U.S. 1093 (1990); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."); *Monarch Cement Co. v. Lone Star Indus.*, 982 F.2d 1448, 1452 (10th Cir. 1992), *citing Aetna Life*,

supra, ("[L]aws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application—often traditional exercises of state power or regulatory authority—whose effect on ERISA plans is incidental."); *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349, 1356-57, (9th Cir.) (state law claims are not preempted unless they fall into one of four categories - "First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan." (citations omitted.)), *amended*, 791 F.2d 799, *cert. denied*, 479 U.S. 949 (1986); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (where a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated."), *cert. denied*, 472 U.S. 1008 (1985); *See also DiPietro-Kay Corp. v. Interactive Benefits Corp.*, 825 F. Supp. 459 (D. Conn. 1993) (employer's claims against insurer for negligence, misrepresentation and violation of Connecticut Unfair Trade Practices Act were not preempted by ERISA).

The denial of certiorari for circuit court cases on both sides of the diverging authority has only increased the uncertainty of the analysis being applied by the lower courts. The Supreme Court now has the opportunity to clear up this confusion after many circuits have considered the issue, with differing results.

ERISA Section 502(a) has been construed by courts to limit the remedies available to those expressly enumerated.[10] ERISA itself also provides no express remedies at all for a plan sponsor such as Tri-State - a further indication that Congress did not intend for preemption to apply to the sale of insurance.[11] Thus, section 502(a) provides civil remedies to a limited group of persons—namely, plan participants, beneficiaries and fiduciaries—*and* defines a limited number of categories of claims that may be asserted.

Importantly, the circuits are generally following this Court's holding[12] that remedies under ERISA are in fact limited to plan beneficiaries, participants or fiduciaries. *See, e.g., Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1288-89 (5th Cir. 1988) ("Where Congress has defined the parties who may bring a civil action founded on ERISA, we are loathe to ignore the legislature's specificity."); *Pressroom Unions-Printers League Income Sec. Fund v. Continental Assurance Co.*, 700 F.2d 889, 892 (2d Cir.) ("legislature [did not]intend . . . to grant subject matter jurisdiction over suits by employers, funds, or other parties not listed in § 1132(a) . . . "), *cert. dismissed*, 464

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[10]*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.").

[11]In general, ERISA's civil enforcement provision grants plan participants and beneficiaries the right to bring a private action to recover benefits under a plan; to enforce ERISA's plan disclosure, funding, and administrative requirements; and to obtain "appropriate relief" for breach of fiduciary duty by an ERISA plan administrator or other person who exercises discretionary control or authority over the plan or its assets. *See* 29 U.S.C. § 1132(a).

[12]In *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), this Court stated that "[t]he express grant of federal jurisdiction in ERISA is limited to suits brought by certain parties . . . as to whom Congress presumably determined that a right to enter a federal court was necessary to further the statute's purposes." *Id.* at 21.

U.S. 845 (1983); *Whitworth Bros. Storage Co. v. Cent. States Pension Fund,* 794 F.2d 221, 228 (6th Cir.) (employer could not maintain suit under ERISA because "Congress intended to limit the parties who could maintain actions pursuant to [ERISA] section 502, [and] that section 502 is an exclusive grant of jurisdiction."), *cert. denied,* 479 U.S. 1007 (1986).

Thus, the Fourth Circuit has found that ERISA preempts Tri-State's state law claims notwithstanding the fact that Tri-State is not authorized by ERISA to institute an action and despite the fact that ERISA contains no remedial provisions addressing the fraud or bad faith of an insurance company vis-a-vis an employer/plan sponsor.

Again, there is no question that the scope of ERISA preemption is broad. Also, there *is* a sound basis for courts to hold that the saving clause of ERISA does not permit plan *participants and beneficiaries* from grafting state insurance law rights and remedies onto ERISA, since ERISA strikes a delicate balance between the interest of participants versus the societal interest in encouraging employers to create plans. But while ERISA has detailed provisions regarding the rights and remedies of plan beneficiaries and participants, ERISA does not have express provisions providing remedies for employers who are non-fiduciary plan sponsors.

The Court is now presented with the opportunity to stop the unnecessary expansion of federal common law by courts like the Fourth, Eighth and Eleventh Circuits. The "relate to" clause is properly viewed expansively when Section 502(a) enumerated parties institute suit, because ERISA provides a remedy to such parties. However, as illustrated by the Second, Fifth, Sixth, Ninth and Tenth Circuit cases discussed above, the "relate to" clause should not be viewed expansively when non-enumerated parties such as Tri-State, a non-fiduciary plan sponsor, institute suit.

Because ERISA does not provide a remedy for misrepresentation or other fraudulent acts committed in connection with the sale of insurance and the computation of insurance premiums, this case gives rise to the issues of whether the dispute "relates to" an ERISA plan in the first instance and whether it is appropriate for courts to create federal common law to replace state law governing disputes not addressed by ERISA. Similarly, this case gives rise to the analogous issue of whether actions can be brought by *parties* not identified in ERISA Section 502(a) (*i.e.*, plan sponsors who are not participants, beneficiaries or fiduciaries) and, if so, whether such actions must be pursued under ERISA, federal common law or under state law.

These are important issues that have important ramifications for all employers who provide welfare benefits to their employees through the purchase of insurance, who are considering doing so, or who may be forced to do so if employer-benefits are mandated.

B. Judicial Construction of the "Saving Clause".

The conflicting interests in allowing states to regulate areas of traditional state law concern versus the need for exclusive federal regulation of employee benefits comes to a head in construing the saving clause of ERISA's preemption provision. Following this Court's lead in *Pilot Life*, it appears to be well accepted in all of the circuits that claims asserted *by participants or beneficiaries* under state law, even state insurance law, are preempted because inevitably they strike at the core concern of ERISA - to provide a uniform and limited remedial scheme. On the other hand, where claims are asserted by persons other than participants or beneficiaries, such as in the case at bar, the courts are split.

In cases involving beneficiaries seeking to invoke state insurance laws to enhance their remedies, this Court has suggested looking, first, to the common sense understanding of the term "regulates insurance" and, second, to the McCarran-Ferguson Act test to determine whether the law regulates the business of insurance. *See, e.g., Metropolitan Life, supra,* and *Pilot Life, supra.*[13] In *Pilot Life,* this Court found that bad faith insurance claims asserted by a plan participant are not insurance regulations of the type that Congress intended to save. Although this Court obviously intended the McCarran-Ferguson Act test to assist courts in distinguishing core insurance concerns from remedies that conflict with the interests embodied by ERISA, the test is not well-suited for addressing the application of preemption to parties not enumerated in ERISA Section 502(a) and has been used to severely limit the scope of the saving clause. Consequently, preemption has been extended into areas not addressed by ERISA.

For example, in the case at bar, the Fourth Circuit perfunctorily applied the McCarran-Ferguson test (without first considering the common sense test) and reached the conclusion that Congress intended to displace state law that would otherwise provide an *employer* with remedies against an insurance company from whom the employer purchased insurance.

On the other hand, where an employer brought suit against an insurance company for failing to ensure that a policy conformed to the requirements of state law, the Sixth Circuit ruled

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[13]In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), this Court referenced a test developed under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.,* to guide courts in determining whether state laws regulate insurance: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id.* at 743 (quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982)).

that pertinent state insurance law was saved from preemption because state insurance law applied to insurance policies purchased by ERISA plans. *Int'l Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 300 (6th Cir.), *cert. denied*, ___ U.S. ___, 112 S.Ct. 2941 (1992).

The Fourth Circuit's ruling in the case at bar is in direct conflict with the Sixth Circuit and is typical of the collective failure of the lower courts to scrutinize this Court's guidance. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.")

C. Judicial Construction of the "Deemer Clause."

The saving clause states that "any law of any State which regulates insurance, banking, or securities" is saved from ERISA preemption. ERISA Section 514(b)(2)(A). The deemer clause limits the effect of the saving clause and states that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or . . . engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts." ERISA Section 514(b)(2)(B).

The deemer clause has been interpreted by the Supreme Court to exempt "ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

> State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other

> insurers, or engaged in the business of insurance for purposes of such state laws. *On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation.* An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. *The insurance company is therefore not relieved from state insurance regulation.* The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. (emphasis added). If the foregoing statements were not sufficiently clear, this Court concluded its analysis in *FMC Corp.* by stating that "[o]ur interpretation of the deemer clause makes clear that *if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts;* if the plan is uninsured, the State may not regulate it." *Id.* at 64 (emphasis added).

This guidance from the Court provides two important dictates that are not being followed by the lower courts throughout the United States. First, lower courts should not extend deemer clause protection to insurance companies. Clearly, the deemer clause prohibits *plans* from being deemed insurers or engaged in the business of insurance. Obviously, insurance companies are insurers and ought to be governed by state insurance law.

Second, the lower courts are ignoring the Court's mandate that only self-funded plans escape state insurance regulation. The common sense concept of a self-funded plan is a plan that contains no insurance. Lower courts and the Fourth Circuit, in particular, however, are extending application of the deemer clause to plans having insurance.

1. Erroneous application to insurance companies.

Although the deemer clause is obviously intended to relieve employee benefit plans from state insurance laws, the clause has been used by insurance companies to avoid the application of state insurance laws to the sale of their insurance policies. Nationwide sold an insurance policy to Tri-State. As noted by Judge Luttig in his dissenting opinion in this case, the sale of the insurance policy and the computation of premiums due were clearly *not* made by the Tri-State benefit plan. It is plain that Tri-State is seeking to hold Nationwide, not the benefit plan, accountable for Nationwide's fraudulent conduct in violation of West Virginia's insurance laws. Tri-State is not seeking to deem the Tri-State benefit plan to be an insurance company.

Nevertheless, the Fourth Circuit majority found, from a review of the plan documents, that Tri-State's benefit plan was "a self-funded one for the most part . . . Accordingly, the district court correctly held that the plan was self-funded and that the Deemer Clause of ERISA would also apply to preempt Tri-State's claims." *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994). Having incorrectly concluded that the plan was self-funded, the Fourth Circuit ruled that the deemer clause applied without considering the identity of the defendant—an insurer. This case presents the Court with the opportunity to clarify application of the deemer clause by holding that plan sponsors asserting premium-related causes of action are not seeking to hold the employee benefit plan accountable for a breach of state insurance law (consequently, the deemer clause is completely inapplicable).

Consistent with *FMC Corp.*, Tri-State is seeking to enforce state insurance regulation of Nationwide, not the Tri-State benefit plan. *FMC Corp.* permits state regulation of companies that insure ERISA plans. The deemer clause relieves ERISA benefit

plans—both insured and uninsured plans—from direct state regulation. The deemer clause does not relieve the plan's insurer from regulation by state law.

2. What is a self-funded plan?

Notwithstanding this Court's decision in *FMC Corp.*, the circuits are split as to when a plan is "self-funded" so as to trigger application of the deemer clause. Some courts have recognized that the deemer clause should be narrowly construed so that employers who transfer risk to insurance companies for the purpose of limiting their own exposure may be protected by state insurance laws. These cases recognize that a self-funded plan, by definition, is not insured.

Another line of cases, however, has broadly construed the deemer clause to mean that an employer who retains some risk through a partially funded plan is precluded from invoking state insurance laws. In particular, the Fourth Circuit, as discussed below, views a self-funded plan as a plan that receives *some* claims reimbursement from the employer (through increased premium obligations).

The issue which must be decided then, and which is of huge importance to all insurance companies and all employers who sponsor health care plans, is whether insurance companies are exempt from state insurance laws where an employer funds some portion of the health care plan. It is Tri-State's contention that this area of law desperately needs a bright line rule stating that insurance companies are subject to state insurance laws in all situations where they are insuring employers against any risk in connection with the sponsorship of an ERISA plan.

The Fourth Circuit has twice applied the deemer clause to plans that were insured. In the instant case, the court reviewed the plan documents and found that Tri-State's benefit plan was "a self-funded one *for the most part*" and applied the deemer

clause to prevent the "saving" of any state law causes of action. *Tri-State Machine*, 33 F.3d at 315 (emphasis added). As explained in the Statement of the Case herein, Nationwide provided insurance to Tri-State and was liable for all claims over specified dollar amounts.

Also, in *Hampton Industries, Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992), the Fourth Circuit applied the deemer clause to a plan that was merely responsible for claims up to $60,000 per year/per employee. The employer purchased insurance from Blue Cross/Blue Shield which required Blue Cross/Blue Shield to pay for any claims over the self-funded amount. *Id.* at 727, n.1. In the insurance industry, this arrangement is known as "stop loss" insurance.

Other circuits, in contradiction to the Fourth Circuit, recognize that the presence of insurance *ipso facto* negates the possibility that a plan is self-funded. In *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), the Sixth Circuit was faced with determining whether certain employee benefit plans were self-insured. Without deciding whether the insured party was the employee benefit plan or the employer, the court noted that insurance proceeds would be payable only when claims exceeded specified ceilings. Consequently, the particular employee benefit plan at issue was not self-insured. *Id.* at 91.[14]

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[14]*Northern Group* was later limited in its holding. In *Lincoln Mut. Casualty Co. v. Lectron Products, Inc. Employee Health Plan*, 970 F.2d 206 (6th Cir. 1992), the Sixth Circuit ruled that a self-funded benefit plan which purchased stop loss insurance to cover its own catastrophic losses remained a self-funded plan. *Lincoln Mutual* did not involve an employer's purchase of insurance as does the case at bar.

This area of law begs for guidance recognizing that employers who purchase an insurance contract to fund an employee benefit plan may require the insurance company to comply with the dictates of state insurance law.

CONCLUSION

The implications of the matters at issue in this appeal are expansive, especially in this age of calls for health care reform and demands for employer-sponsored health care. Tri-State bargained for insurance to shift its risk and burden of providing health care benefits. What it received in return was insurance fraud.

The plain language of ERISA indicates that it was not designed to protect insurance companies from complying with insurance regulations, and most certainly not from breach of contract and tort claims arising out of fraudulent billing practices unrelated to benefits administration.

There are several reasons why the issues in this lawsuit merit the attention of the Supreme Court, especially at this point in time. First, a trend has swept the country's courts, developed from the early preemption cases decided by this Court, to interpret the force of ERISA preemption more and more broadly so as to cover transactions and parties that Congress never intended. Second, the analysis performed to determine the breadth of ERISA's preemptive effect needs to be retooled. Presently the "relates to" analysis is not a test at all, because it knows no bounds. Third, the saving and deemer clause analysis has been modeled after an old insurance law standard that has simply not been workable or meaningful outside of the beneficiary or participant context of preemption analysis. The net effect of this is to gut state insurance laws as they may apply to employer-sponsored health coverage.

Finally, and most importantly, the strong interest in having employers create and continue ERISA welfare plans has been undermined by the misapplication of preemption analysis. When employers should be encouraged to create plans by, for example, buying health insurance for their workers, they are actually discouraged from doing so by the present interpretation of ERISA which permits insurance companies to sell insurance policies to employers without accountability under state insurance laws.

Respectfully submitted,

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APPENDIX

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
SEPTEMBER 23, 1991

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

MEMORANDUM OPINION AND ORDER

Currently pending is the plaintiff's motion for partial summary judgment. Defendant has filed its opposition, as well as a motion to strike plaintiff's motion. No reply has been filed by the plaintiff. Said matters are now ripe for disposition.

The material facts underlying this matter are not in dispute. From November of 1983 through July of 1987, Tri-State Machine, Inc. ("Tri-State") contracted with Nationwide Life Insurance Company ("Nationwide") for group health insurance for Tri-State's employees. After July of 1987, Tri-State became self-insured for health benefits to its employees, with Nationwide providing stop-loss insurance as well as providing administrative claims processing functions. During July of 1989, the relationship between the parties terminated.

Tri-State then commenced this civil action in state court against Nationwide asserting common law breach of contract claims and statutory claims under West Virginia law. Nationwide removed the action to this Court, basing jurisdiction upon

OPINION

NIEMEYER, Circuit Judge:

We are presented with the issue of whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims of Tri-State Machine, Inc., for improper claims processing and mismanagement against Nationwide Life Insurance Company. Nationwide Life issued and administered a group insurance policy to provide health care benefits for Tri-State's employees under an employee benefit plan. The district court ruled that Tri-State's state law claims were preempted by ERISA and, upon Tri-State's failure to amend its complaint to state a claim under ERISA, dismissed the action. Tri-State contends on appeal that it is a "mere purchaser" of insurance and that its claims against Nationwide Life are not preempted by ERISA because they do not "relate to" an employee benefit plan. Tri-State also contends that its claims are based on state laws regulating insurance, which are saved from preemption under § 514(b)(2)(A) of ERISA. For the reasons that follow, we conclude that the district court properly held that all of Tri-State's state law claims are preempted by ERISA and affirm.

I

The employee benefit plan of Tri-State Machine, Inc., provides medical, disability, dental, and death benefits to Tri-State employees and their beneficiaries. The terms of the plan give participants notice that the plan is governed by ERISA and that they are entitled to certain rights and protections under ERISA. Until 1989, the plan was insured and administered by Nationwide Life Insurance Company under a group policy and under a Cash Priority Plan Funding Agreement between Nationwide Life and Tri-State. Under the agreement, claims for benefits were self-funded by Tri-State up to a $25,000 limit for each employee

for each year, beyond which Nationwide Life agreed to pay claims under stop-loss insurance. All claims by employees were to be submitted to Nationwide Life, who reserved the right to determine whether the claims were payable. Nationwide Life provided monthly reports to Tri-State detailing Tri-State's liability under the agreement. Nationwide Life entered into a subcontract with First Benefits Agency, Inc., to administer the plan.

Effective July 1, 1989, Nationwide Life terminated its arrangements with Tri-State. Alleging that Nationwide Life mismanaged and improperly carried out its claims processing responsibilities under the policy and agreement, Tri-State filed suit in the West Virginia Circuit Court of Ohio County in February 1990, alleging breach of contract, breach of implied covenants of good faith and fair dealing, bad faith tort, insurance bad faith, and violation of the West Virginia Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 through 33-11-10. Tri-State asserted that Nationwide Life failed to administer the plan according to the terms of the agreement and mismanaged the claims processing procedures by paying claims to wrong medical providers, by issuing coverage cards in the names of employees never associated with Tri-State, by charging claims to accounts of individuals who had not submitted claims, by paying claims not covered, by denying claims that were covered, and by requesting reimbursement from Tri-State for claims improperly paid. Tri-State also charged that Nationwide Life delayed processing of claims in a year during which Tri-State had met its stop-loss liability, deflecting claims into a new policy year so that claims would become the obligations of Tri-State by reason of the annual self-funding limit of $25,000 for each employee.

Nationwide Life removed the case to the federal district court on diversity grounds and also on grounds that the claims were preempted by ERISA. On Tri-State's motion for partial summary judgment to declare that ERISA did not preempt its

state law claims, the district court denied the motion and held that "ERISA preempts all of Tri-State's claims based upon West Virginia laws relating to the health insurance plan upon which its complaint is based." The court held specifically that 29 U.S.C. § 1144(a) preempts all of Tri-State's claims and that the exception to preemption contained in 29 U.S.C. § 1144(b)(2)(A), known as the Savings Clause, did not apply because the "Deemer Clause," contained in § 1144(b)(2)(B), excludes from the Savings Clause self-funded benefit plans. The court found that the plan in this case was a self-funded plan and that the stop-loss insurance for coverage above the self-funded amounts did not "change this outcome." Thereafter the court ordered Tri-State to notify the court whether it intended to pursue the case under ERISA. Although Tri-State indicated its intention to do so, it never amended its complaint to state a claim under ERISA, and the district court dismissed the complaint. This appeal followed.

II

We are presented with the legal issue of whether Tri-State's state law claims, arising out of allegedly wrongful claims processing by Nationwide Life, are preempted by ERISA. Since the question is one of law, we will review the district court's orders *de novo*.

ERISA's preemption clause provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar *as they may now or hereafter relate to any employee benefit plan* . . . .

29 U.S.C. § 1144(a) (emphasis added). This clause has been broadly interpreted by the courts to carry out Congress' intent to displace any state law efforts to regulate ERISA matters. *See,*

e.g., FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) ("the preemption clause is conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) ("the section's preemptive scope [is] as broad as its language"); *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410, 418 (4th Cir. 1993) ("it is frequently observed that the force of ERISA's preemption is strong and its scope wide"). Thus, any law "that relates to" a plan is preempted by 29 U.S.C. § 1144(a), and the phrase "relates to" is given its common sense meaning as having "connection with or reference to such a plan." *Shaw,* 463 U.S. at 96-97.

Although ERISA's preemptive sweep is broad, the "Savings Clause" contained in 20 U.S.C. § 1144(b)(2)(A), which saves from preemption state laws that regulate insurance, is stated almost as broadly. This clause preserves for state regulation any law "which *regulates insurance* banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739-40 (1985), the Supreme Court construed the Savings Clause to apply only to state laws regulating core insurance issues. Considering a complex state statutory scheme which regulated, among other things, the substantive content of health insurance policies, the Supreme Court held that state insurance regulations that mandate particular policy benefits are saved from preemption by the Savings Clause. It concluded that Congress intended to save from preemption only those state laws that regulate the traditional business of insurance to the extent that it involves contractual arrangements for protection against financial loss through the spreading of risk. To guide this inquiry, the Court put forth the following three-part test developed under the McCarran-Ferguson Act:

> *[F]irst,* whether the practice has the effect of transferring or spreading a policyholder's risk; ***second,*** whether the practice is an integral part of the policy relationship between the insurer and the insured; and ***third,*** whether the practice is limited to entities within the insurance industry.

471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982)). Thus, a claim based on state law or regulation that regulates the business of insurance as defined by *Metropolitan Life's* three-part test is "saved" from preemption by virtue of the Savings Clause, § 1144(b)(2)(A), even if the claim "relates to" an employee benefit plan within the meaning of § 1144(a).

ERISA takes the further step of limiting the Savings Clause by stating that an employee welfare benefit plan itself is not, under state law, to be "deemed" an insurance company for purposes of the Savings Clause. This so-called "Deemer Clause" provides:

> *Neither an employee benefit plan* . . . nor any trust established under such a plan, *shall be deemed to be an insurance company,* or other insurer . . . or to be engaged in the business of insurance or banking for purposes of any law or [sic] any State purporting to regulate insurance companies, insurance contracts . . . .

29 U.S.C. § 1144(b)(2)(B) (emphasis added). The Deemer Clause has been interpreted by the Supreme Court "to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC Corp. v. Holliday,* 498 U.S. at 61. The Court reasoned that "[b]y forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws purporting to regulate insurance.' " *Id.* Thus, "[s]tate laws that directly regulate insurance are 'saved' but do not reach self-

funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." *Id.*

While *Metropolitan Life* placed state insurance regulations mandating particular insurance policy benefits within the area preserved for state regulation, the Supreme Court in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), held that state insurance law regulating *claims processing* did not regulate the "business of insurance" and therefore, was not saved from preemption. In *Pilot Life,* an injured employee sued the insurance company that issued and administered his employer's disability plan, asserting improper acts in connection with the processing of a claim for benefits. The suit was based on state common law tort and contract principles. The Supreme Court concluded as a first step that "common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a) [29 U.S.C. § 1144(a)]." *Id.* at 48. The Court then proceeded to determine whether such claims against an insurance company for improper claims processing fell within the Savings Clause. Applying the test of *Metropolitan Life,* the Court concluded that such claims were not made under state laws regulating the core insurance business and therefore were not saved by the Savings Clause. Consequently, the state law claims were held to be preempted. 481 U.S. at 57.

In *Custer v. Pan American Life, supra,* we applied the *Pilot Life* holding to conclude that the West Virginia Unfair Trade Practices Act, which regulates insurance companies by prohibiting certain unfair trade and settlement practices, was not saved from preemption. Accordingly, we held that claims made under the West Virginia law relating to an insurance company's improper claims processing or administration of an employee

benefit plan were preempted. The West Virginia Supreme Court, also relying on *Pilot Life*, had earlier reached the same conclusion. *See Ball v. Life Planning Services, Inc.*, 421 S.E.2d 223, 227 (W. Va. 1992) (holding that an action under subsection 9 of West Virginia Code 33-11-4 is preempted under ERISA). *See also Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-24 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (concluding, in a case decided before *Pilot Life* but consistent with it, that an action alleging improper claims processing is not saved from preemption because it does not regulate the business of insurance under ERISA).

With these principles in mind, we turn to the issues before us.

III

Tri-State contends that the state law claims alleged in its complaint are not preempted by ERISA, relying on two different theories. First, it argues that it is a "mere purchaser" of insurance and that therefore the claims arising from its status as a mere insurance purchaser are not "related to" an employee benefit plan within the preemption clause of ERISA, 29 U.S.C. § 1144(a). Tri-State also argues that since its claims arise under the West Virginia Unfair Trade Practices Act, which regulates insurance companies, they are preserved to state regulation under the Savings Clause of ERISA, 29 U.S.C. § 1144(b)(2)(A). To support its second argument, Tri-State points to W. Va. Code § 33-11-1, which states that the purpose "of this article . . . [is] to regulate trade practices *in the business of insurance*" (emphasis added).

Tri-State's first argument will not detain us long, since the broad sweep of 29 U.S.C. § 1144(a) provides for preemption of claims under any state law that "relate to any employee benefit plan." No serious argument is made that the package of health

care benefits provided by Tri-State to its employees through the policy purchased from Nationwide Life is not a plan. In addition to the fact that the plan's language announces participants' rights under ERISA, the nature of the arrangement, which provides benefits paid for by the employer to employees and their beneficiaries in connection with their employment, meets the criteria defining a plan under ERISA. *See* 29 U.S.C. § 1002(1); *Custer*, 12 F.3d at 417.

Moreover, there can be little doubt that the claims relate to the plan. Tri-State's complaint particularizes a list of wrongs committed by Nationwide Life, including its paying claims to wrong medical providers, issuing coverage cards in the names of employees never associated with Tri-State, charging claims to accounts of individuals who had not submitted claims, paying claims not covered, denying claims that were covered, and delaying processing of claims in a year when the stop-loss limit had been reached in order to deflect them into a new policy year to be charged against Tri-State under its self-funding obligations. All of these allegations are essentially complaints about the processing of claims under an employee benefit plan and, therefore, *relate to* the plan in the common sense meaning of that phrase. Indeed the Supreme Court in *Pilot Life* specifically stated: "The common law causes of action raised in *Dedeaux's* complaint, *each based on alleged improper processing of a claim* for benefits under an employee benefit plan, undoubtedly meet the criteria for preemption under § 514(a)." 481 U.S. at 48 (emphasis added). *See also Custer*, 12 F.3d at 420.

Concluding that Tri-State's claims relate to an employee benefit plan and thus fall under ERISA's broad preemption provision of 29 U.S.C. § 1144(a) does not, however, end the inquiry. Tri-State's second argument is that because its claims fall under the West Virginia Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 through 33-11-10, establishing unfair trade

practices in the business of insurance, its state law claims are preserved from federal preemption under the Savings Clause. The question thus presented is whether the trade practices identified in the West Virginia Act regulate the business of insurance as that phrase is used in ERISA, 29 U.S.C. § 1144(b)(2)(A), and interpreted in *Metropolitan Life,* 471 U.S. at 743 (establishing the three-prong test for determining whether a state law regulates the *business of insurance*).

The Unfair Trade Practices Act, Article 11 of the Insurance chapter of the West Virginia Code, specifically attempts to place itself within the meaning of "business of insurance" as defined by the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* The first section of the article states:

> The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty five (Public Law fifteen, seventy-ninth Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

W. Va. Code § 33-11-1. Since the term "business of insurance" in the McCarran-Ferguson Act has been adopted as the basis for defining the scope of the Savings Clause of ERISA, *Metropolitan Life,* 471 U.S. at 743, Tri-State argues that the West Virginia regulation of insurance fits into the exception to ERISA's broad preemption, even though the West Virginia Act, having been enacted before the federal statute, is not adopted in response to ERISA. Although the argument has some logical appeal, further analysis reveals a superficiality that fails to take into account the substance of the Unfair Trade Practices Act.

The Act provides a long list of prohibited acts in the marketing, selling, and administering of insurance in West Virginia. It prohibits false or misleading statements or advertising as to the contents of a policy and also prohibits engaging in unfair settlement practices, in an apparent effort to provide truth in insurance advertising and fairness in insurance administration. *See, e.g.*, W. Va. Code §§ 33-11-3 & 33-11-4. The Act prohibits many of the practices alleged by Tri-State in its complaint to constitute improper claims processing. But this type of regulation is not unique to the business of insurance, and it does not target, at least in these provisions, the core business of insurance which involves contracts of protection under which risk is spread among policy holders.

We recently interpreted this precise statute and concluded that since the West Virginia Unfair Trade Practices Act does not simply regulate the business of insurance as defined in *Metropolitan Life*, it is not saved from preemption in connection with claims relating to an employee benefit plan. *See Custer*, 12 F.3d at 419-421. In *Custer*, an insurance company issued a policy to an employer and administered it as part of an employee benefit plan. When the plaintiff sued the insurance company for denying benefits and canceling the policy, allegedly in violation of West Virginia law, we concluded that the claims were preempted, holding "that Custer's claims under West Virginia law relating to improper claims processing or administration are not saved from preemption by the savings clause." 12 F.3d at 420. We concluded that our decision was directly controlled by the Supreme Court's holding in *Pilot Life*, 481 U.S. at 50 (holding that state law improper claims processing actions are not directed at the insurance industry alone and do not relate to the spreading of risk), and this court's holding in *Powell*, 780 F.2d at 423-24 (concluding that an action alleging improper claims processing is

not saved from preemption because it does not regulate the business of insurance under ERISA).

The holding in *Custer* applies here to require a determination that Tri-State's claims are also not saved from preemption under § 1144(b)(2)(A). *See also Ball v. Life Planning Services, Inc.*, 421 S.E.2d 223, 227 (W. Va. 1992) (holding that West Virginia Code § 33-11-4(9) relates to unfair claims settlement practices and therefore is the same type of claim that the Supreme Court found to be preempted by ERISA in *Pilot Life).*

The district court also found an alternative basis to hold that Tri-State's state law claims were preempted. It concluded that even if Tri-State's claims fell within the Savings Clause, the employee benefit plan involved here would be regulated by ERISA, and not state law, under the Deemer Clause. The district court concluded that the group health insurance plan issued by Nationwide Life and sponsored by Tri-State was a self-funded plan, and thus under the Deemer Clause of ERISA, it was not subject to regulation under state law purporting to regulate the business of insurance. *See FMC Corp.*, 498 U.S. at 61. It appears from our review of the plan documents that the plan was indeed a self-funded one for the most part, with stop-loss insurance to cover an individual's claims in excess of $25,000. Tri-State's complaint alleges as much: "Under the policy, Tri-State was self-insured for certain portions of benefits payable under the group health insurance plan." Complaint ¶8. We have held previously that the purchase of stop-loss insurance does not convert a self-funded plan to an insured plan for preemption purposes. *See Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 653 (4th Cir. 1991). Accordingly, the district court correctly held that the plan was self-funded and that the Deemer Clause of ERISA would also apply to preempt Tri-State's claims.

IV

Finally, Tri-State contends that the district court "improperly dismissed Tri-State's suit in its entirety because Tri-State's complaint must necessarily state a cause of action under ERISA or federal common law." The difficulty with the contention is the underlying assumption that somehow Nationwide Life or the district court was required to identify and define Tri-State's claim when Tri-State itself refused to do so over a two-year period. The district court carefully reviewed the procedural steps taken by Tri-State and concluded, in essence, that Tri-State simply failed to prosecute its case under ERISA. On a review of the record, we cannot say that the district court abused its discretion in bringing this tortured pleading battle to an end.

After the case was removed from state court on the basis of diversity jurisdiction and ERISA preemption, Tri-State sought to remand the action. When the district court denied its motion, Tri-State filed a motion for partial summary judgment declaring that ERISA did not preempt Tri-State's state law claims. By a Memorandum Opinion and Order dated September 23, 1991, the district court concluded that the state law claims were preempted and denied Tri-State's motion to declare otherwise. Shortly thereafter, Tri-State filed a motion for reconsideration and requested, alternatively, that the court make the necessary finding to permit it to seek appellate review under 28 U.S.C. § 1292(b). The district court denied the motion for reconsideration, observing that nothing new had been presented by Tri-State, but it did give Tri-State the opportunity to seek leave to appeal under 28 U.S.C. § 1292(b). In its petition for permission to appeal, Tri-State claimed that its case was "simply a breach of contract and an independent tort case" and "Never did the plaintiff [Tri-State] intend to involve, nor does the complaint affect, ERISA issues." When this court summarily denied permission to appeal, Tri-State petitioned the district court to vacate and re-

enter its order denying reconsideration of its ERISA preemption ruling, believing that Tri-State's late filing of a petition to appeal was the basis for denial of permission. The district court refused Tri-State's request and ordered that Tri-State inform the court whether it intended to pursue an action under ERISA. On June 8, 1992, plaintiff filed a notice in which it informed the court that Tri-State "intends to pursue this action under ERISA." Tri-State, however, did not file an amended complaint to state any claim under ERISA. Rather, over five months later, it filed another motion to obtain from the court a certification under Federal Rule of Civil Procedure 54(b) that the district court's preemption ruling was final. At that time, Tri-State again argued the preemption issue and sought to amend three paragraphs of its complaint to enhance its effort to circumvent ERISA preemption. The amendments sought were not substantive and would only have altered Tri-State's characterization of the parties' roles. Because Tri-State failed to prosecute the case through the filing of an ERISA claim, and only pursued alternative avenues to challenge the district court's ruling, the district court concluded, again reviewing the merits of the preemption issue:

> In that this issue [ERISA preemption] has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the Court hereby GRANTS summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.

Against this procedural history, the district court had a well-founded basis to conclude that Tri-State was only interested in obtaining appellate review of the preemption issue and that, by not pursuing an ERISA claim, Tri-State was staking the success of its action solely on the question of whether its state law claims survived. The district court's decision to dismiss the complaint in

these circumstances was not an abuse of discretion. Accordingly, we affirm.

AFFIRMED

LUTTIG, Circuit Judge, dissenting:

The majority holds that the unfair trade practices article of the West Virginia insurance code, which was enacted "to regulate trade practices in the business of insurance," W. Va. Code § 33-11-1, is not a state "law . . . which regulates insurance," 29 U.S.C. § 1144(b)(2)(A). Thus, it concludes, Tri-State's improper claims processing action under that statute is not saved from preemption. According to the majority, this result is dictated by our recent decision in *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993), in which we interpreted the Supreme Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), as holding that all state improper claims processing actions filed against an insurance company are not saved from preemption. In my view, *Pilot Life* did not sweep quite so broadly, and applying here the saving clause analysis undertaken by the Supreme Court in *Pilot Life* requires us to hold that Tri-State's state action *is saved* from preemption. Accordingly, I dissent.

In *Pilot Life*, the Supreme Court addressed whether ERISA preempts a beneficiary's or participant's cause of action for improper claims processing brought under Mississippi's common law of bad faith, holding that the action was not saved from preemption under ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A). In reaching this conclusion, the Court first determined that a "common-sense understanding" of the language of the saving clause confirms that a state law only "regulates insurance" when it is "specifically directed toward th[e insurance] industry." 481 U.S. at 50. Applying this common-sense understanding of the clause's text, it concluded that the

Mississippi common law of bad faith does not regulate insurance, because it is rooted in general principles of Mississippi tort and contract law. *Id.* It next reviewed Mississippi's bad faith doctrine under the three criteria the Court employs to interpret the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, and found that these factors also did not support a conclusion that the Mississippi law "regulates insurance." 481 U.S. at 50-51. And finally, the Court looked to the "role of the saving clause in ERISA as a whole," *id.* at 51, concluding that Congress intended as exclusive the civil remedies that ERISA provides to *beneficiaries and participants* alleging improper claims processing. *Id.* at 52-57.

Only last term, in *Custer*, we considered whether ERISA preempted a beneficiary's improper claims processing action brought under West Virginia's insurance code, *see* W. Va. Code § 33-11. In that case, we assumed, mistakenly I believe, that *Pilot Life* broadly held that all "state cause[s] of action for improper claims processing filed against an insurer [are] not saved from preemption under § 1144(a)." 12 F.3d at 420. Proceeding on this assumption as to the scope of *Pilot Life*, we reasoned that *Pilot Life* directly controlled Custer's West Virginia action, which was filed against an insurance company for improper claims processing, and, without even engaging in the actual *Pilot Life* analysis, held that Custer's state action was not saved from preemption.*

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* We also concluded in *Custer* that the case was controlled by our decision in *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). In *Powell*, we addressed a beneficiary's state law claims against her former employer and the insurance company that administered the employer's uninsured ERISA plan for maladministration of her benefits claims. We held that each of Powell's state law claims related to the employer's ERISA plan, and were therefore pre-empted. In a passage relied on by the majority for the proposition that improper claims processing actions are pre-empted, *ante* at 9-10, we rejected Powell's

(Continued on next page)

Now, relying on *Custer's* assumption that the *Pilot Life* holding extended to all state law improper claims processing actions, and again largely ignoring the three-step saving clause analysis employed by the Court in *Pilot Life*, the majority summarily concludes in this case that *Custer* requires a holding that Tri-State's improper claims processing action is not saved from preemption.

In my view, the Supreme Court did not hold in *Pilot Life* that all state actions for improper claims processing fall outside the saving clause. The only question before the Court in *Pilot Life* was whether a claim by a *beneficiary* or a *participant* under a *state common-law doctrine of bad faith* (indeed, only Mississippi's law) was saved from preemption. In deciding that it was not, the Supreme Court neither addressed state improper claims processing actions by parties other than beneficiaries and participants or different actions brought under other state laws.

In *Custer*, our mistake was immaterial because the *beneficiary's* cause of action there in question was one specifically identified by the Court in *Pilot Life* as governed exclusively by

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(Continued)

argument that her claim against Connecticut General, the plan's administrator, was saved from pre-emption because it was brought under a state law that regulated insurance. *Id.* at 423-24. Although Connecticut General is, in fact, an insurance company, we held that, in its capacity as administrator, it was not all engaged in the "business of insurance" but rather served purely administrative functions, and therefore that the state law, as applied to Connecticut General, did not constitute a state regulation of insurance that was saved from pre-emption. *Id.*

Our holding in *Powell* turned, therefore, on the fact that Connecticut General was not engaged in the business of insurance, rather than on the fact that Powell's action was for improper claims processing. That an insurance company that administers but does not insure an ERISA plan is not engaged in the business of insurance for purposes of the saving clause hardly bears on this case, since Nationwide, which provided Tri-State with stop-loss insurance, obviously was engaged in the business of insurance.

ERISA. 481 U.S. at 56. Thus, our holding that Custer's cause of action was preempted was correct notwithstanding our misapprehension of the contours of the *Pilot Life* holding and our attendant failure to engage in the full inquiry undertaken by the Court in *Pilot Life*. Here, however, the majority is not saved by happenstance.

Unlike in *Pilot Life*, a "common-sense understanding" of the statutory text, 481 U.S. at 50, does support the argument that the West Virginia law before us "regulates insurance." If any law can be said to be "specifically directed toward th[e insurance] industry," *id.*, it is this statute, which, by terms, was enacted to, and does, "regulate trade practices in the business of insurance . . . ." W. Va. Code § 33-11-1.

Also here, unlike in *Pilot Life*, the West Virginia statute as applied to Tri-State's action (and, in my view, to the action in *Custer*) regulates "the business of insurance" under the McCarran-Ferguson Act. 15 U.S.C. § 1012. Tri-State alleges that Nationwide violated the West Virginia insurance code by deliberately and fraudulently delaying its charging of benefit claims against Tri-Sate's account in order to avoid coverage for those claims under its stop-loss policy with Tri-State. *See* Appellant's Br. at 5. Applying the West Virginia statute to regulate the determination of which claims are covered under Tri-State's stop-loss insurance policy with Nationwide certainly affects an "integral part of the policy relationship between the insurer and the insured," *Pilot Life*, 481 U.S. at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)), since it certainly would "define the terms of the relationship between the insurer and the insured," *Pilot Life*, 481 U.S. at 51. It also would, by regulating when and how liability on benefit claims would be transferred from Tri-State to Nationwide, directly involve, if not actually "effect[,] a spreading of [Tri-State's] risk." *Id.* at 50. And, as noted above, the statute by terms is

"specifically directed toward [the insurance] industry." *Id.* Tri-State's action plainly does, therefore, regulate "the business of insurance" in accordance with the McCarran-Ferguson Act. *See United States Dept. of Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993) ("There can be no doubt that the actual performance of an insurance contract falls within 'the business of insurance' [for purposes of McCarran-Ferguson Act] . . . ."); *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) ("The relationship between the insurance company and the insured, the type of policy which could be issued, its *reliability, interpretation and enforcement*—these were the core of the 'business of insurance' [that Congress addressed in the McCarran-Ferguson Act]." (Emphasis added)).

Finally, and most importantly, Tri-State's state action does not, as the state actions in both *Custer* and *Pilot Life* did, run afoul of "the legislative intent concerning the [exclusivity of the] civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." *Pilot Life*, 481 U.S. at 52. While it is plain that the remedies provided in section 502(a) to *beneficiaries* and *participants* were intended to be exclusive, and therefore preempt state actions such as those in *Pilot Life* and *Custer*, it is equally plain that that section does not expressly provide any remedy to employers such as Tri-State, let alone one that Congress clearly intended to be exclusive.

In sum, I believe that we misassessed the reach of the *Pilot Life* holding in *Custer* and therefore failed to engage in the full *Pilot Life* analysis. We ultimately reached the correct conclusion in *Custer*, but for reasons that we never considered. However, for the same reasons that we did not consider in *Custer*, we, as a court, are incorrect here.

Because, in my view, Tri-State's state cause of action alleging that Nationwide fraudulently processed claims to avoid coverage on those claims is, under *Pilot Life*, saved from preemption, I cannot join the majority's opinion holding otherwise.

I also disagree with the majority's alternative holding that, because the ERISA plan here was essentially self-funded, the deemer clause applies to preempt Tri-State's claims. *Ante* at 10-11. The deemer clause, by its terms, only applies to "employee benefit plan[s]" and "trust[s] established under such []plan[s]," 29 U.S.C. § 1144(b)(2)(B). It does not speak at all to insurance companies such as Nationwide or claims against them. "By forbidding States to deem *employee benefit plans* 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves *plans* from state laws 'purporting to regulate insurance.'" *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (emphasis added). Nationwide obviously is not an "employee benefit plan," and the deemer clause has no application to Tri-State's claims against it. *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) ("Since Connecticut General [Life Insurance Company] is not an 'employee benefit plan,' the deemer clause is inapplicable to it."); *see FMC Corp.*, 498 U.S. at 61 ("An insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause."). Thus, the district court's holding that the deemer clause preempts Tri-State's claims is, I believe, incorrect. Accordingly, I dissent from the majority's affirmance of that holding as well.

CERTIFICATE OF SERVICE

I hereby certify that, in accordance with Rule 29 of the Rules of the Supreme Court of the United States, three true and correct copies of the within Petition were sent on November 28, 1994 by first class mail, postage pre-paid, to all of the parties required to be served as follows:

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